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SAFETY AND HEALTH TOPIC SHEET NO. 2: NEAR MISSES: LEARNING FROM FAILURE

A safety and health topic sheet aimed at raising awareness of hazards in the rope access industry. The series may be of use as a toolbox talk.

1 INTRODUCTION

1.1 Human failure is as important as a rigging or mechanical failure. There are numerous causes of falls from a height which result from human failure. These include: poor communication, complacency, over confidence and lack of knowledge.

1.2 Within the rope access industry, many have had 'moments of stupidity'; unwitnessed near misses that might have resulted in a consequence greater than an increased heartrate and a sudden realisation of your own mortality.

1.3 It might have been a forgotten leg-loop, a karabiner clipped back to a 'cowstail' rather than an anchor point, descenders threaded up-side-down, a karabiner misconnection, etc. All these occurrences are considered to be near misses.

1.4 It is important to report them to your company! Without this, they don't become a learning experience for others.

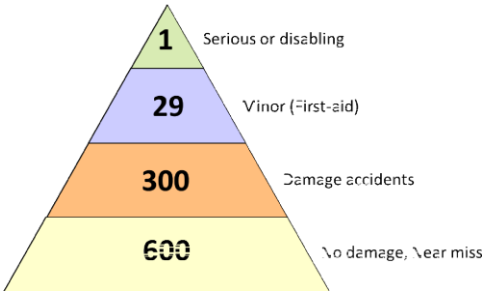
LEARN LESSONS FROM OTHERS.

HOWEVER, YOU CAN ONLY DO THIS IF THEY REPORT THEM!

2 WHAT CAN GO WRONG …

2.1 An unreported near miss, e.g. a small fall from height, may at some point result in an injury or fatality elsewhere.

2.2 One theory[1] tells us that for a large number of 'No damage, Near miss' events there will be a smaller number of 'damage accidents' and – ultimately – a 'serious or disabling' event, e.g. a fatality.



[1] Frank E. Bird, Jr (1921 – 2007)

2.3 Accordingly, one way to help prevent the more serious incidents is to report the near misses. It might then be possible to identify a pattern in the types of incidences, which could lead to a way to prevent them.

2.4 Nobody wants to report a foolish mistake; nor ought they take a conscious risk without consequence to save time or effort. However, near miss information can be used to make changes, prevent accidents and save lives.

Case study
Description Technicians carrying out window cleaning did not have enough rope to reach the ground on a long drop. They asked other technicians to re-rig the ropes to reach the floor whilst they waited in a position of safety. Using mobile phones to communicate, they waited until the rigging technicians had finished moving the ropes and gave the all-clear to continue.
Causes Unsuitable rigging as the ropes could have been rigged to reach the floor, removing the necessity to re-rig during operations. There was a lapse in judgment in not checking that the ropes reached the floor before starting work.

3 WHY THINGS CAN GO WRONG …

3.1 Things can go wrong for many reasons:

- There may be a lapse of judgment.
- Someone may decide to cut a corner.
- A near miss may not be reported.
- There may be poor supervision.
- A technician may lack experience or knowledge.
- Someone may be overconfident.
- Communication may be poor.
- There may be a false sense of safety.
- Procedures may be ineffective or inefficient.
- There may be a ‘blame culture’.

4 WHAT YOU CAN DO AND HOW YOU CAN DO IT …

4.1 You should always:

- Take time to assess what is going on. You’re less likely to have a lapse in judgement when tasks are thought through properly.
- Allow adequate time to complete tasks. Don’t encourage rushing.
- Encourage near miss reporting (If necessary, reporting can be anonymous). You can ‘learn from failure’

- Ensure good standards of supervision. There should be sufficient number of manager(s) and/or supervisor(s).
- Use the correct people for the task. Protect and teach those who are inexperienced.
- Make sure that technicians are aware of the risks and the potential severity of an incident. Training and information is vital.
- Ensure that communication is suitable and sufficient. Assess each task separately and ask yourself, “What’s different today?”
- Ensure that procedures are kept under review. Work methods evolve and improve; make use of the most efficient and effective methods available.
- Encourage a “no blame culture”. Where possible, ensure that technicians learn from their mistakes (rather than being punished for them).

5 ADDITIONAL CONSIDERATIONS …

5.1 Encourage technicians to report and discuss near misses and experiences that they have encountered or heard about.

5.2 Utilise toolbox talks or task assessment briefings. Vary the topics and encourage participation from all those involved.

5.3 In many cases, discussing these ‘topic sheets’ will be a good *aide memoire* in helping to prevent incidents.

6 ACTION

6.1 Review your management system’s procedures for ‘near misses’.

7 REFERENCES

7.1 Further information can be found in:

(a) IRATA International code of practice for industrial rope access (Third Edition, September 2016)[2]:

- Part 1, 1.4.2.2, Training and competence
- Part 1, 1.4.2.3, Management and supervision
- Part 2, 2.2.6, Procedures and personnel to be in place before work begins
- Part 2, 2.2.6.2, Personnel
- Part 2, 2.3, Selection of rope access technicians
- Part 2, 2.3.2, Experience, attitude and aptitude
- Part 2, 2.4, Competence

7.2 For a list of current (and past) safety communications by IRATA, see www.irata.org

[2] www.irata.org/downloads/2055

8 RECORD FORM

8.1 An example Safety and Health Topic Sheet: Record Form is appended.

8.2 Members may have their own procedure(s) for recording briefings to technicians and others.

9 FURTHER READING

9.1 Reducing error and influencing behaviour, HSG48 (HSE)[3]

9.2 Near miss reporting (HSE)[4]

9.3 Human factors: Behavioural safety approaches – an introduction (HSE)[5]

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3 www.hse.gov.uk/pubns/priced/hsg48.pdf

4 https://www.hse.gov.uk/pubns/near-miss-book.htm

5 www.hse.gov.uk/humanfactors/topics/behaviouralintor.htm

IRATA SAFETY AND HEALTH TOPIC SHEET – RECORD FORM					
Site:					
Date:					
Topic(s) for discussion:			Topic Sheet No. 2: Near misses: Learning from failure		
Reason for talk:					
Start time:			**Finish time:**		
Attended by *Please sign to verify understanding of briefing*					
Print name:			**Signature:**		
Continue overleaf (where necessary)					
Matters raised by employees:			**Action taken as a result:**		
Continue overleaf (where necessary)					
Briefing leader *I confirm I have delivered this briefing and have questioned those attending on the topic discussed.*					
Print name:		**Signature:**		**Date:**	
Comments:					